NHS Family doctor services registration *GMS1*

Patient's details

Please complete in BLOCK CAPITALS and tick ☐ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous GP practice while at that address

Address of previous GP practice

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:

Postcode

Service or Personnel number: Enlistment date: Discharge date: (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

☐ I live more than 1.6km in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

**Not all doctors are authorised to dispense medicines*

☐ **Signature of Patient** ☐ **Signature on behalf of patient**

Date ___/___/___

What is your ethnic group?

Please tick one box that best describes your ethnic group or background from the options below:

White: ☐ British ☐ Irish ☐ Irish Traveller ☐ Traveller ☐ Gypsy/Romany ☐ Polish

☐ Any other white background (please write in):

Mixed: ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian

☐ Any other Mixed background (please write in):

Asian or Asian British: ☐ Indian ☐ Pakistani ☐ Bangladeshi

☐ Any other Asian background (please write in):

Black or Black British: ☐ Caribbean ☐ African ☐ Somali ☐ Nigerian

☐ Any other Black background (please write in):

Other ethnic group: ☐ Chinese ☐ Filipino

☐ Any other ethnic group (please write in):

Not stated: ☐

Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

062021_006 Product Code: GMS1

NHS Family doctor services registration

GMS1

To be completed by the GP Practice

Practice Name

Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Practice Stamp

Authorised Signature

Name Date ____/____/____

SUPPLEMENTARY QUESTIONS – These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

c) ☐ I do not know my chargeable status

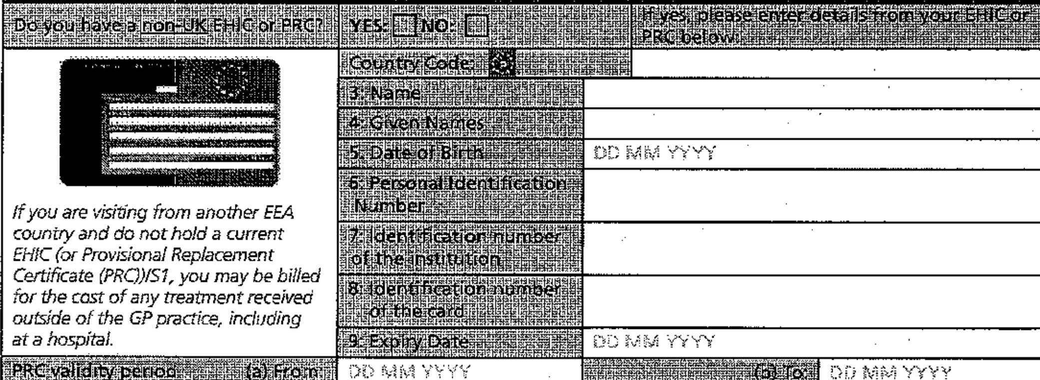
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		Date:	DD MM YY
Print name:		Relationship to patient:	
On behalf of:			

Complete this section if you live in an EU country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

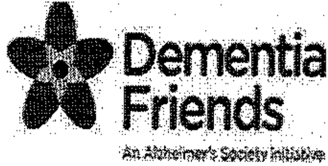


Do you have a non-UK EHIC or PRC?	YES: ☐ NO: ☐	If yes, please enter details from your EHIC or PRC below:
	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.	9: Expiry Date	DD MM YYYY
PRC validity period (a) From:	DD MM YYYY	(b) To: DD MM YYYY

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.**

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with Business Service Authority for the purpose of recovering your NHS costs from your home country.



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NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

INTRODUCTION

This questionnaire can be used to capture data for new patient registrations and will also help to establish a base-line view of the patient life-style and will assist the nurse / doctor in carrying out a new patient health check. The information provided will assist also in the identification of "at risk" patients and focus care advice on at risk areas.

To the Patient:

To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. Please book a **New Patient Health check** appointment with the practices Health Care Assistant.

Surname: .... Forename(s): ....

Date of Birth: .... Marital status: ....

Address: ....

.... Postcode: ....

Home tel: .... Mobile: ....
(We will remind you by text of your appointments and send you other Health messages)

I ....consent to text messages being sent. Date.........................

Email address: ....

Occupation: ....

Weight (approx): .... Height: ....

Date of completion of this form: ....

If child of school age What School do they attend:

Great Homer Street Medical Centre

Name of School: ....

Telephone Number/Address of school ....

SMOKING

Do you smoke? Yes / No

If Yes, how many:
Cigarettes per day .... Cigars per day .... Ounces of tobacco per day ....

How old were you when you started smoking? ....

Would you like help quitting? YES.............. NO...............

You can contact FAG ENDS free or make an appointment to see our GP for treatment
FAGS ENDS phone number 0800 195 2131

EX-SMOKERS

How old were you when you stopped smoking? ....
How much did you smoke per day? ....

PASSIVE SMOKING

Are you exposed to smoke at work? Yes / No At home? Yes / No

ALCOHOL

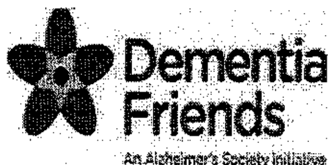
For the following questions please circle the answer which best applies
1 drink = 1/2 pint of beer or one glass of wine or 1 single spirits

Men: How often do you have EIGHT or more drinks on one occasion?
Women: How often do you have SIX or more drinks on one occasion?

Never *Less than monthly* *Monthly* *Weekly* *Daily or Almost Daily*

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never *Less than monthly* *Monthly* *Weekly* *Daily or Almost Daily*



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How often during the last year have you failed to do what was normally expected of you because of drinking?

Never *Less than monthly* *Monthly* *Weekly* *Daily or Almost Daily*

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No *Yes on one occasion* *Yes on more than one occasion*

DIET

Do you add salt to your food after cooking? Yes / No
Do you have a varied diet including milk, meat, vegetables and fruit? Yes / No
Has your Cholesterol been checked in the last 2 years? Yes / No

EXERCISE

Do you take regular exercise? Yes / No

If yes, what sort of exercise? ....

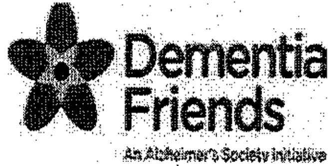
How many times per week? ....

Do you suffer from any of these conditions (please circle):- Diabetes, Asthma, Coronary Heart Disease, Stroke/TIA, Hypertension, Cancer, Epilepsy, Chronic Kidney Disease, Hypothyroidism, Mental Health, Depression, Dementia, Peripheral Arterial Disease (PAD), Heart Failure, Osteoporosis, Rheumatoid Arthritis, Learning Difficulties or Learning Disabilities.

Do you receive Palliative Care? Yes/No

FAMILY HISTORY

Is there any of the following in your family *(father, mother, brother, sister)* before age of 65?
Heart Disease (heart attacks, angina) Yes / No Which family member? ....
Stroke? Yes / No Which family member? ....
Cancer? Yes / No Which family member? ....
Site of cancer? ....



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MEDICATION

Please give details of any medication which you take (prescribed or otherwise): PLEASE PROVIDE A LIST FROM YOUR PREVIOUS SURGERY) and **bring all your medication with you for your first appointment.**

Name of drug: .... Dosage: ....

Name of drug: .... Dosage: ....

ALLERGIES

Are you allergic to any substances or foods? Yes / No
If yes, please give details:

....

PAST MEDICAL HISTORY

Please give details of any hospital treatment as an in-patient:

....

Please give details of any treatment for any chronic medical conditions:

....

Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound:

....

Are you Homeless ....Living in a Hostel................................Other.............................

IMMUNISATIONS

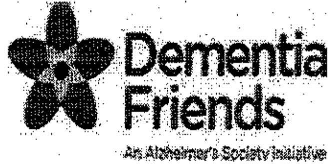
Dates of Triple/polio/HIB: ....

Dates of MMR: ....

Date of last Tetanus: ....

FEMALE PATIENTS

Date of most recent cervical smear: ....



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Result of most recent smear: ....

Please give details of any complications in pregnancy:
....

CARERS

Do you need / have anyone who looks after you or your daily needs as Carer? Yes / No
If "Yes", would you like them to deal with your health affairs here? Yes / No
(the receptionist can help with these arrangements)

Do you care for anyone else? Yes / No

Name of person you are caring for;

Name .... Relationship

Address ....

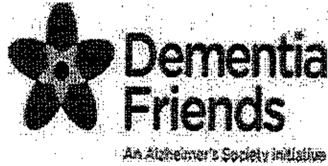
Postcode .... Phone Number

NEXT OF KIN

Name .... Relationship ....

Address ....

Post Code .... Phone Number ....



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PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

A	White
	British
	Irish
	Any other white background please write in below

B	Mixed
	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background please write below

C	Asian or Asian British
	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please write below

D	Black or Black British
	Caribbean
	African
	Any other black background please write below

E Chinese or other ethnic group

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Chinese
Any other please write below

Declined

Are you an Asylum Seeker YES NO

LANGUAGE

What is your main spoken language? ....

RELIGION ....

INTERPRETER

Do you require an Interpreter? Yes/No

Thank you for completing this questionnaire.

Proof of ID Needed – Utility Bill, Tenancy Agreement, Bank Statement (not a mobile phone bill), photo ID passport or driving licence.

Great Homer Street Medical Centre

Summary Care Record (SCR)

Dear Patient

The NHS in England is introducing the **Summary Care Record (SCR)**, which will be used in **emergency care.**

The record will contain information about medicines you are taking, any allergies and any bad reactions to medicines you have. This ensures those caring for you can treat you safely by having the right information. Your record will be available to authorised healthcare staff who provide your care anywhere in England, with your permission. This enables them to have immediate access to important information about your health should you become ill or have an accident.

This practice is supporting SCR and as a registered patient you have a choice:

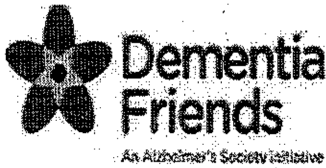
- **Yes I would like a Summary Care Record** – no action needs to be taken, a Summary Care Record will be created for you

- **No I would NOT like a Summary Care Record** – there is an enclosed opt out form. Please complete the form and hand it to a member of staff at the practice.

If you require more information, you can talk to a member of staff, or the dedicated NHS Summary Care Record Information Line on 0300 123 3020, PALS 0300 7900 224 or visit the website www.nhscarerecords.nhs.uk. Additional copies of the opt out form can be obtained from the practice, printed from the above website or requested from the dedicated NHS Summary Care Record Information Line.

You can choose NOT to have a Summary Care Record and you can change your mind at any time by informing the practice.

Children under 16 will automatically have a Summary Care Record created unless their parent/guardian chooses to opt them out. If you are a parent/guardian of a child under 16 and feel they are old enough to understand, you should make the record available to them.



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www.greathomerstreetsurgery.nhs.uk

OPT OUT FORM

REQUEST FOR MY CLINICAL INFORMATION TO BE WITHHELD FROM THE SUMMARY CARE RECORD

If you DO NOT want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title................. Surname/FamilyName...

Forename(s)...

Address...

..

..

Postcode.................... Phone No......................... Date of birth.........................

NHS Number (if known)...

B. If you are filling this form on behalf of someone else or a child, their GP practice will consider this request

Your name... Signature.....................

Relationship to patient.. Date..............................

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely. You records will stay as they are now with information being shared by letter, email, fax or phone.

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www.greathomerstreet.co.uk

TEXT MESSAGING (SMS) CONSENT FORM

DECLARATION

I consent to the practice contacting me by text message for the purposes of health promotion and for the appointment reminders.

I acknowledge that the appointment reminders by text are an additional service and that these may not take place on all/or on any occasion, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time.

The surgery does not offer a reply facility to enable patients to respond to texts directly.

Text messages are generated using a secure facility however I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure, however the practice will not transmit any information which would enable an individual patient to be identified.

I agree to advise the practice if my mobile number changes or if this is no longer in my possession.

Patient Name...DOB...............

Mobile Telephone Number....................................

Patient signature...

Date.........................

THE PRACTICE DOES NOT SHARE MOBILE PHONE CONTACT DETAILS WITH ANY EXTERNAL ORGANISATION

Date: Jan 2016
Review Date: Dec 2017
Author: MSS
Patient Registration Pack Guidance v01

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www.greathomerstreet.co.uk

EMAIL CONSENT FORM

DECLARATION

I consent to the practice contacting me by Email for the purposes of health promotion, PPG meetings and for the appointment reminders.

I acknowledge that the appointment reminders by email are an additional service and that these may not take place on all/or on any occasion, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the email message facility at any time.

Please be aware that email is not secure or confidential. Similar to a postcard, it is possible for unauthorised people to intercept and read your emails. Please do not put information into your email that you would prefer to keep confidential.

The Practice Email Inbox will not be monitored more than once a day. We will provide you with a response within two working days but on occasion, for example, Dwhen Doctors are on holiday, it may take four working days. If you have not heard within that period, we advise you to ring the Practice and let the receptionist know.

GREAT HOMER STREET MEDICAL CENTRE PATIENT EMAIL SERVICE IMPORTANT: This service must not be used for urgent medical problems. If you have an urgent medical problem please contact the Practice by phone (0151 295 9393) or by attending. You can also phone 111 for health advice or go on the internet: www.nhs.uk. In an emergency, dial 999.

Patient Name...DOB...............

Email address...

Mobile Telephone Number....................................

Patient signature..

Date........................

Date: April 2018
Review Date: April 2019
Author:RA/DB
Patient Registration Pack Guidance v01